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	175044	A. BUILDING _____ B. WING _____	C 12/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #KS00061848.	F 000		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility reported a census of 88 residents and the sample was 4. Based on observation, record review, and interviews the facility failed to assess for the safe use of lift recliners for 3 (#1, #4, and #3) residents of the sample. The facility also failed to have interventions in place for the prevention of falls for 1 (#1) of 4 residents reviewed for falls. Findings included: - Resident #1's quarterly Minimum Data Set (MDS) 3.0 dated 9/10/12 recorded a Brief Interview for Mental Status (BIMS) score of 11 (mild impairment), needed extensive assistance for bed mobility, transfer, locomotion on unit, dressing, toileting and hygiene, was not able to balance without staff assistance, had no falls, and was occasionally incontinent of bladder/bowel. The CAA (Care Area Assessment) dated 1/17/12	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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for falls recorded the resident was at risk for falls related to requiring staff assist for transfers, toileting, and mobility for safety. The resident had a diagnosis of Parkinson's disease (a progressive neurological disease characterized by muscular shaking, slowing of movement, weakness and peculiarity of gait/posture) and received medications for it, also at risk due to multiple medication use and history of memory and cognitive loss.

The annual MDS 12/3/12 recorded a BIMS score of 11, needed extensive assistance for bed mobility, transfer, dressing, and toileting, needed limited assistance with walking in room, was not able to balance without staff assistance, had 2 falls, 1 with no injury, 1 with injury (except major), and was occasionally incontinent of bladder.

The Fall risk assessment dated 9/10/12 recorded the resident was at risk for falls due to requiring assistance with incontinence, used mobility device when ambulating, had unsteady gait, had transfer difficulties, had impaired judgement/decision making, and had periods of confusion/disorientation. The assessment noted the resident slept in the recliner.

The Lift Chair assessment dated 11/29/12 (after the resident had 2 falls out of the lift recliner) recorded the resident had physical/cognitive limitations, recorded the staff discussed in length with the resident about his/her using a lift chair. The chair belonged to the resident and had it for years. The resident said "where would I sleep if I did not have it?". The resident agreed to have the remote stored in the chair's side pocket along with the cord. The resident did not want to give up

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his/her lift chair. It was felt the resident could get out of any chair/recliner when he/she had the desire to get up by him/herself. Thirty minute checks continued. The resident said he/she appreciated the staff for their concern about his/her safety and getting hurt worse the next time, but he/she did not want to change anything at this time.
Evaluation of Learning: learning accomplished, verbalized understanding.

The care plan dated 9/25/12 for falls recorded the resident was at risk for falls, injuries and drug related side effects due to weakness, confusion, and Parkinson's Disease and included the following interventions:
The resident slept in recliner in his/her apartment and had recliner moved to his/her room here, assist him/her in transferring to/from the recliner, remind him/her to use call light, and wait for assistance before transferring into or out of recliner, reinforce proper foot wear when up to decrease fall risk, assist as needed to help him/her apply shoes before standing, ambulated with 2 wheel walker for short distances, and used wheel chair for longer, provide stand by and guided assistance for his/her safety, non skid strips in front of recliner and in front of toilet to help prevent slipping.

Nurses notes (NN) dated 11/5/12 at 11:57 A.M. late entry the resident slid to the floor at the bottom of his/her recliner after raising the lift chair to the high position without assistance at approximately 6:40 A.M. on 11/2/12. The resident was alert with confusion and staff noted a strong odor of urine. The resident said he/she just slowly slid down to the floor, denied any pain/discomfort.

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The facility notified the physician for submission of urine culture/sensitivity test due to positive urine dip stick. Order received to start Keflex, an antibiotic. The staff suggested to the resident, only use lift chair controls with staff assist and the resident and family were in agreement. On 11/2/12 fall prevention included the resident would request assist with transfers, permission requested and received to remove lift (recliner) controls from the resident's reach.

NN 11/20/12 at 3:13 P.M. late entry recorded at approximately midnight on 11/17/12, direct care staff called this nurse to resident's room. The direct care staff told the nurse over the phone that the resident "fell and laying in a pool of blood." Upon arrival the resident lay on his/her back, legs and arms extended. The vitals signs were fine. Range of motion noted to be full. Eyes tracked within limits. The resident said he/she was not in pain when asked. The staff assisted the resident to a sitting position and noted the occipital area (back part of the head) had a laceration. The nurse cleaned and held pressure to the site of injury. Staff notified security, the local ambulance called and paged the physician to get order to send the resident to the emergency room.

NN 11/17/12 at 4:53 A.M. the resident returned from the emergency room via nursing home transportation. Six staples to laceration to back of head, to be removed in 14 days, also returned with a prescription for Levaquin (an antibiotic) for UTI.

NN 11/17/12 at 12:50 P.M. the resident had a laceration closed with staples to the occipital area of his/her head that continued to ooze

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serosanguinous (blood appearance) fluid, denied any recollection of what he/she did or how he/she came to fall. Continued to be confused and having difficulty expressing needs/thoughts. Commuted tomography (CT) scan at hospital during early A.M. showed no evidence of intracranial issues and no fracture. Laboratory tests done showed UTI and the resident started on Levaquin (an anti biotic) and neurological checks continued.

The Facility investigation into the event night of 11/16/12 at midnight, the resident had an unwitnessed fall. The staff found him/her on the floor at midnight in front of his/her recliner, he/she had blood pooled under his/her head. The resident could not say how he/she got on the floor except that ' I hit my head. " On 11/16/12 at 11:21 P.M. the resident put on his/her call light that the staff answered in less than 1 minute and assisted the resident to the bathroom. The staff assisted the resident back to the recliner where he/she preferred to sleep. The staff placed the recliner remote in the side pouch out of her reach (as the care plan specified). When the staff found the resident on the floor the recliner was in the incline position half way and the remote was on the floor. There was no staff in the room between the time the staff left and the time the staff found the resident on the floor. We believed by the way the resident lay and the condition the recliner was in that the resident attempted to get up (he/she had not put on his/her call light) and fell out of the chair. On 11/17/12, staff provided thirty minute visual checks for safety and when resident was in the recliner unattended in room staff placed the walker out of resident's reach to ensure he/she used the call light. On 11/19/12 preventative

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medications to help with frequent urinary tract infections (UTI's).

NN 11/17/12 at 5:45 P.M. the staff had just transferred the resident to the recliner from the wheel chair, needed assist of 2 staff due to weakness, denied pain to laceration site, staples intact, remote in side pocket, walker out of reach.

NN 11/17/12 at 11:45 P.M. recorded resident voiced no complaints, asleep in recliner, staples remained intact, area was clean/dry, remote to lift chair in side pocket and walker out of reach.

NN 11/18/12 at 7:34 P.M. some confusion as to time noted when talking about things in general. The resident used call light for assist to bathroom, reminded not to use remote for chair but to use call light and wait for assistance.

NN 11/19/12 at 3:17 A.M. "the resident was confused and did not remember what he/she did when he/she fell, 30 minute checks done for safety, recliner control is out of reach as is walker, and call light clipped to chair."

Observation on 12/17/12 at 9:25 A.M. direct care staff D came out of the resident's bathroom with the resident who walked with a 2 wheel roller walker. The staff had a gait belt around the resident and the resident walked slowly to the lift recliner. The staff assisted the resident to his/her lift recliner and sat down in the chair. The staff reached for the remote that was in the pocket by the recliner on the right side. The staff placed the wheel chair by the resident's glass cupboard that stood on his/her left side, and placed the call light in reach. The resident had non skid strips by

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F 323	Continued From page 6 his/her lift chair and in front of the toilet seat. Interview with direct care staff E on 12/17/12 at 2:20 P.M. said the resident had a lift recliner and the staff placed the controls in the pocket next to the side of the recliner. They removed the wheel chair and the walker and placed it behind the resident's chair so he/she could not reach them. The staff said the resident could reach down into the recliner pocket and get the control for the lift recliner, but said if it was out of sight he/she would not think of using it. The staff said they clipped the call bell by the resident's hand so that it was what he/she saw first and then would use it. Interview with administrative nursing staff B on 12/17/12 at 2:40 P.M. the staff said after the resident's fall out of the lift recliner they became aware that they had to start assessing all the resident ' s who had a lift recliner. The staff said they had not started yet, but the plan was to do it on admission and then quarterly. He/She said the facility did not have a written policy on that. The staff were aware the resident had fallen out of the lift recliner before and the intervention at the time was to keep the lift chair control out of his/her reach. The staff said the staff might not have tucked the cord all the way in the pocket so the resident was able to get a hold of it. The facility failed to assess the cognitively impaired resident's lift recliner for safe usage, and failed to provide effective and timely interventions for the prevention of falls for this resident who experienced two falls from the lift recliner one in which resulted in the resident requiring staples to the head.	F 323		

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- Resident #4's annual Minimum Data Set (MDS) 3.0 dated 11/5/12 recorded a Brief Interview for Mental Status (BIMS) score of 13 (cognitively intact), needed extensive assistance with bed mobility, transfer, locomotion on/off unit, dressing, toilet use, and personal hygiene, had difficulty balancing without staff support, did not walk in room, had impairment on both sides of lower extremities, used a walker and a wheel chair, and had no falls since last assessment.

The CAA (Care Area Assessment) dated 11/6/12 for delirium recorded the resident had a 1 point decrease on the BIMS from his/her last assessment. Due to the resident's short term memory loss he/she did have some difficulties making decisions and relied on staff for reminders of events and relied on his/her family for assistance with finances and complex medical decisions.

CAA for falls dated 11/6/12 recorded the resident had no falls recently, but was at risk for falls related to requiring assistance with toileting due to incontinence, his/her history of heart disease, arthritis, impaired hearing, impaired vision, required nursing assistance with transfers due to transferring difficulty, had to wear built up shoe, had periods of confusion/disorientation, had impaired judgement and decision making, had decline in cognitive skills, used multiple medications, at times used a mechanical lift for transfers with 2 staff assist for safety. The resident slept in his/her recliner at night by his/her preference.

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Fall risk assessment dated 11/1/12 recorded the resident was at risk for falls.

The care plan dated 11/20/12 recorded for falls, injury, and drug related side effects due to limited mobility, pain and use of pharmaceutical interventions and for the staff to take orthostatic blood pressure/pulse weekly, fold the walker and place out of reach when not in use, remind the resident to use call light for needs, and on 4/7/12 keep the recliner remote out of reach when he/she was in the recliner.

Nurses notes (NN) dated 4/7/12 at 3:18 A.M. recorded that at 2:20 A.M. the staff heard the resident calling for help. The staff found the resident on the floor, lying on his/her back, in front of his/her electric recliner, which was in the highest position. The resident said he/she did not know what happened, and said "I must have pushed the button in my sleep". The staff noted no injury, and the resident denied hitting his/her head.

The clinical record lacked evidence the facility assessed for the safety of the resident's use of an electric lift recliner.

Observation on 12/17/12 at 9:40 A.M. the resident sat in a wheel chair in the TV room.

Observation on 12/17/12 at 10:40 A.M. the resident had an electric lift chair in their room. The controls of the lift chair hung down onto the floor.

An interview on 12/17/12 at 2:20 P.M. with licensed nursing staff C said he/she believed the

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resident had a lift recliner in his/her room and believed the resident lifted him/herself out of the chair, but needed staff help to get in/out of the chair.

An interview 12/17/12 at 2:24 P.M. with direct care staff E said the resident had a lift chair/recliner in his/her room. The staff said the resident was able to use the controls but did not generally do that unless staff were in the room. The staff said they did not have to hide the control from the resident. The staff said the resident needed help with transfers.

Interview 12/17/12 at 2:40 P.M. with administrative nursing staff B said the resident fell out of wheel chair in the past, and that the facility had no assessment for the safe use of the lift recliner for this resident.

The facility failed to follow care plan interventions for the prevention of falls and failed to assess for the safe use of the lift recliner.

- Resident #3's admission Minimum Data Set (MDS) 3.0 dated 11/6/12 recorded a BIMS (Brief Interview for Mental Status) score of 15 (cognitively intact), needed limited assistance from staff for bed mobility, transfer, walk in room, locomotion on/off unit, dressing and toileting, had a fall history on admission but no falls since admission.

The CAA (Care Area Assessment) for falls dated 11/6/12 recorded the resident had a fall on 10/26/12 in the wellness center, and was sent to the emergency room for an evaluation. The

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resident sustained a fracture to his/her left wrist, and was at risk for future falls related to requiring staff assist with transfers and ambulation, and received physical/occupational therapy. Per nursing assessment dated 10/26/12, the resident was at risk for falls due to partial loss of balance while walking, unsteady gait, gait pattern changes when walking, and loss of arm movement.

The Fall risk assessment dated 10/26/12 recorded the resident's favorite chair was his/her rocking chair, but that he/she slept in bed, and that he/she was at risk for falls.

The care plan for falls dated 11/26/12 recorded the resident had a fracture of the left wrist and for the staff to monitor orthostatic blood pressure weekly, remind the resident to use the call light for assist for safety, ensure it was always in reach, to keep the room well lit/clutter free, and for the staff to use a gait belt for transfer/ambulation.

Observation on 12/17/12 at 10:40 A.M. the resident sat in his/her wheel chair reading a book. The resident was alert/oriented. The resident said he/she broke his/her left wrist when he/she stood up in exercise class while living in his/her apartment, his/her foot caught something and he/she fell. The resident said the cast will come off tomorrow, and then will have physical therapy so he/she would stay for another week at the facility.

Observation on 12/17/12 at 2:15 P.M. the resident sat in his/her lift chair with the control next to him/her on the table.

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F 323	Continued From page 11 Interview on 12/17/12 at 2:35 P.M. with direct care staff E said the resident had falls, took him/herself to the bathroom and that was the issue. The staff said they constantly gave the resident several cues/reminders that if he/she needed to do anything, he/she must use the call light. The staff said the resident was alert/oriented and not confused. An interview 12/17/12 at 2:40 P.M. with administrative staff B said the facility did not conduct an assessment for the lift chair in resident's room. The facility failed to assess for the safe use of the lift recliner.	F 323		